

**TRANSPORT INFORMATION CHECKLIST**  
**FOR PERSONS ON INVOLUNTARY STATUS**

Name of individual transported \_\_\_\_\_ DOB \_\_\_\_\_  
Transport From \_\_\_\_\_ Time: \_\_\_\_\_  
Transport To \_\_\_\_\_  
Name of Person Ordering Transport \_\_\_\_\_ Emergency Contact Info \_\_\_\_\_  
Assessment done day of transport? ☐ No ☐ Yes Date of transport: \_\_\_\_\_

*Pursuant to 18 V.S.A. §7511, secure transport and escort shall be done in a manner which prevents physical and psychological trauma, respects the privacy of the individual, and represents the least restrictive means necessary for the safety of the patient. Secure transport shall only be used when an individual poses a risk of harm to self or others and a less restrictive alternative is clinically contraindicated.*

**Considerations in Determining Mode of Transportation:**

(Additional space below for elaboration, if needed.)

1. What is the client's history of transport behavior? ☐ cooperative ☐ unwilling ☐ triggering ☐ unknown?
2. Have the client's friends/family been consulted regarding transportation options? ☐ No ☐ Yes
3. Has the client been consulted regarding transportation options? ☐ No ☐ Yes
4. Is the client able to regulate his or her behavior? ☐ No ☐ Yes client approachable to discuss options? ☐ No ☐ Yes
5. Any adverse events in last 24 hours of which transporters ought to be aware? ☐ No ☐ Yes
6. Does client's mood seem stable and sustainable for the length of transport ordered? ☐ No ☐ Yes
7. If client was given PRN medication in the ED, have you discussed whether medical monitoring via ambulance would be necessary? ☐ No ☐ Yes

**Other supporting reasons for mode of transport provided, OR please reference from above**  
**Please be mindful of behavioral considerations for those who may be transporting and not know the patient.**  
**Thank you.**

**Signatures REQUIRED on second page ►**

**Mode of Transportation RECOMMENDED by DOCTOR** (see below, for decision tree)

<u>Vehicle</u>	<u>Accompaniment</u>	<u>Restraints</u>
<input type="checkbox"/> Private transport	<input type="checkbox"/> friend/family	<input type="checkbox"/> None
<input type="checkbox"/> Mental health van alternative	<input type="checkbox"/> mental health staff	<input type="checkbox"/> Metal
<input type="checkbox"/> Unmarked alternative escort	<input type="checkbox"/> support specialist	<input type="checkbox"/> Soft
<input type="checkbox"/> Ambulance	<input type="checkbox"/> sheriff in vehicle	
<input type="checkbox"/> Sheriff's cruiser	<input type="checkbox"/> Other: Peer, advocate etc	
<input type="checkbox"/> Other _____		

1- \_\_\_\_\_  
Signature of Psychiatrist

2- \_\_\_\_\_  
Social Worker with phone/pager

Please Print Names:

► Provide this form (both pages) to: (Fax 802-241-0100 Attn: Pamela Shover)

**DECISION TREE**

